IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER– Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

7007 0710 0002 7979 0475

May 20, 2009

Shane Quesnell
Preferred Community Homes - Milliken
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Milliken, provider #13G053

Dear Mr. Quesnell:

Based on the Medicaid/Licensure survey completed at Preferred Community Homes - Milliken on May 5, 2009, by our staff, we have determined that Preferred Community Homes - Milliken is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of Participation on Client Protections (42 CFR 483.420), Facility Staffing (42 CFR 483.430) and Client Behavior & Facility Practices (42 CFR 483.450). To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Preferred Community Homes - Milliken to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **June 19, 2009. To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than June 8, 2009.**

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Preferred Community Homes - Milliken ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective May 5, 2009, through September 2, 2009. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **June 17, 2009**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208)364-1804
fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 2, 2009. If a request for informal dispute resolution is received after June 2, 2009 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

NW/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	05/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Michael Case, LSW, QMRP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactive Disorder A.M. In Charge - Staff In Charge BMP - Behavior Management Plan DVD - Digital Video Disc ICF/MR - Intermediate Care Facility for Persons with Mental Retardation IDT - Interdisciplinary Treatment Team IPP - Individual Program Plan JOG - Juvenile Offenders Group LPC - Licensed Professional Counselor NOS - Not Otherwise Specified PPD - Pervasive Developmental Disorder PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Professional RSC - Resident Service Coordinator TV - Television	W 000	Preparation and implementation of this plan of corrections does not constitute admission or agreement by Milliken Heights with the facts, findings, or other statements as alleged by the State agency dated May 5, 2009. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Milliken Heights specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review, and individual and staff interviews it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for the individuals residing at the facility. This	W 104	**W104 483.410(a)(1) Governing Body** Please See Credible Letter dated July 1, 2009.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

T Naylor 7/6/09 Regional / Interim Admin.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 failure negatively impacted 7 of 7 individuals (Individuals #1 - #7) residing at the facility. Failure of the governing body to ensure the policies and procedures were sufficiently developed, and to ensure staff were sufficiently trained regarding sex offender treatment and suicide risk, resulted in the facility being found out of compliance with three (3) Conditions of Participation, and individuals being placed in serious and immediate jeopardy. The findings include: 1. Refer to W122 - Condition of Participation for Client Protections and related standard level deficiencies as they relate to the facility's failure to provide the necessary client protections and ensure steps were taken to protect individuals. 2. Refer to W158 - Condition of Participation for Facility Staffing and related standard level deficiencies as they relate to the facility's failure to ensure competent, trained staff were available to provide supervision and meet the behavioral needs of the individuals residing in the facility. 3. Refer to W266 - Condition of Participation for Client Behavior and Facility Practices and related standard level deficiencies as they relate to the facility's failure to ensure that techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored.	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 120	**W120 483.410(d)(3) Services Provided with Outside Services** Please See Credible Letter dated July 1, 2009.	

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W 120	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure outside services met the needs for 7 of 7 individuals (Individuals #1 - #7) who received sex offender treatment. This resulted in outside services not being sufficiently coordinated. The findings include: 1. Individual #2's 6/3/08 IPP stated he was a 15 year old male whose diagnoses included Asperger's Syndrome, mild mental retardation, PDD and ADHD. His record included a Court Decree documenting probationary requirements which included no supervision by individuals under the age of twenty-one. During an observation on 4/30/09 at 5:35 p.m., the staff noted to be working with Individual #2 was asked his age and stated he was 20 years old. The facility's records were reviewed and documented no less than 4 staff working at the facility were under the age of 21 years old, including one graveyard staff. During a telephone interview on 5/1/09 from 2:35 - 2:50 p.m., Individual #2's Probation Officer stated she had taken over Individual #2's case about one month ago. During that time she had not heard from the facility. She stated the Sex Offender Treatment Specialist had telephoned on 4/30/09 and left a message but she had not yet spoken with him. The Probation Officer stated she had spoken with Individual #2 on two occasions since she took over his case. The Probation Officer stated Individual #2 should not be working with anyone under the age of 21 at any time. She stated Individual #2 needed at	W 120		

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W 120	Continued From page 3 least 2 polygraphs, one for disclosure and one for maintenance. Any additional polygraphs would be whatever the treatment program required. The Probation Officer stated she would like monthly reports from the facility, but stated she was not aware if monthly reports had been requested in the past. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Administrator stated no one had contacted Individual #2's Probation Officer, and stated the previous Probation Officer had not requested information from the facility so none had been provided. The Administrator and the QMRP, who was present during the interview, stated they were not aware of the requirements outlined in Individual #2's probation and were not aware he was not to be supervised by staff under the age of twenty-one. When asked who provided coordination between the Sex Offender Treatment Specialist and Individual #2's Probation Officer, the Administrator stated no one was because "it has never been asked." When asked about the other requirements of Individual #2's probation, neither the Administrator or QMRP could provide information. Without sufficient coordination between the facility, Individual #2's Probation Officer, and the Sex Offender Treatment Specialist, the facility would not be able to ensure the requirements of Individual #2's probation were being met, which created a potential for Individual #2 to be subjected to probation violations. The facility failed to ensure Individual #2's probation services were adequately coordinated. 2. Refer to W127 as it relates to the facility's	W 120		

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W 120	Continued From page 4 failure to ensure individuals' sex offender treatment was sufficiently coordinated to develop and implement sufficient staff training and oversight to ensure the monitoring and supervision of individuals during the graveyard shift. 3. Refer to W149 as it relates to the facility's failure to ensure the design, implementation, and monitoring of policies and procedures related to sex offerer treatment and suicidal ideation were coordinated with the Sex Offender Treatment Specialist, who was also the LPC. 4. Refer to W166 as it relates to the facility's failure to ensure the services with the Sex Offender Treatment Specialist were sufficiently coordinated to ensure the facility's environment and the facility's policy for Sex Offender Treatment met the needs of the individuals residing at the facility. 5. Refer to W169 as it relates to the facility's failure to ensure the services with the Sex Offender Treatment Specialist, who was also the LPC, were sufficiently coordinated to ensure the facility's professional, paraprofessional, and nonprofessional staff members received on-going training regarding sex offender treatment and suicidal ideation. 6. Refer to W191 as it relates to the facility's failure to ensure the services with the Sex Offender Treatment Specialist, who was also the LPC, were sufficient to ensure staff received adequate training and oversight on sex offender treatment and suicidal ideation. The facility failed to ensure services with the Sex	W 120		

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W 120	Continued From page 5 Offender Treatment Specialist, who was also the LPC, were sufficiently coordinated for Individuals #1 - #7.	W 120		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, review of the facility's policies and procedures, investigations, record review, and individual and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals. The facility failed to have a system in place that assured the safety of its individuals; the facility failed to have policies and procedures that were sufficiently developed to help staff identify behaviors and interventions that would assure individuals' safety; the facility failed to provide adequate training to its staff; and the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. These failures resulted in a lack of effective systems to prevent individuals from being subjected to neglect and potential exploitation. The cumulative effect of these failures demonstrated the facility's non-compliance with federal requirements and constituted serious and immediate jeopardy to the health and safety of its individuals. The findings include: 1. Refer to W120 as it relates to the facility's failure to ensure outside services met the behavioral needs of each individual.	W 122	**W122 483.420 Client Protections** Please See Credible Letter dated July 1, 2009.	

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W 122	Continued From page 6 2. Refer to W124 as it relates to the facility's failure to ensure sufficient information was provided to parents/guardians on which to base consent decisions. 3. Refer to W127 as it relates to the facility's failure to ensure individuals supervision needs were not being neglected which resulted in the potential for individuals to be subjected to on-going sexual abuse, exploitation and mistreatment from other individuals. This resulted individuals being placed in serious and immediate jeopardy. 4. Refer to W149 as it relates to the facility's failure to ensure the facility's policy and procedures to prevent abuse, neglect, and mistreatment were adequately developed, implemented, and monitored. 5. Refer to W153 as it relates to the facility's failure to ensure all allegations of neglect or exploitation were immediately reported to the Administrator. 6. Refer to W154 as it relates to the facility's failure to ensure a thorough investigation was conducted for all allegations of neglect and exploitation. 7. Refer to W157 as it relates to the facility's failure to ensure appropriate corrective action was taken in response to all allegations of neglect and exploitation. 8. Refer to W158 - Condition of Participation for Facility Staffing and related standard level deficiencies as they relate to the facility's failure to	W 122		

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W 122	Continued From page 7 provide competent, trained staff to meet individuals' health, safety, and behavioral needs. 9. Refer to W266 - Condition of Participation for Client Behavior and Facility Practices and related standard level deficiencies as they relate to the facility's failure to ensure that techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored.	W 122	**W124 483.420 (a)(2) Protection of Client Rights**	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 1 of 4 individuals (Individual #2) whose written informed consents were reviewed. This resulted in conflicting information being provided to an individual's guardian regarding restrictive interventions. The findings include: 1. Individual #2's 6/3/08 IPP stated he was a 15 year old male whose diagnoses included Asperger's Syndrome, ADHD, and mild mental retardation. His IPP stated he had a history of inappropriate sexual conduct, inappropriate sexual touching, and of making sexual	W 124	Please See Credible Letter dated July 1, 2009.	

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W 124	Continued From page 8 statements. His IPP stated he had a safety plan in place that was to be followed at all times. a. Individual #2's record included a Written Informed Consent, dated 3/1/09, for a Safety Plan. The Safety Plan, undated, included the following 8 items: - No unsupervised contact with computers or the Internet. - No babysitting or being placed in positions of authority over people under the age of 18. - No contact with 1-900 numbers. - No unsupervised contact with children under the age of 18 years and/or his sibling. - Close monitoring when with peers if they were developmentally delayed. - Adult supervision by an approved adult who was aware of the safety plan, twenty-four hours a day, seven days a week. - Involvement in an adolescent sexual program specifically geared to individuals with developmental disabilities. - Involvement in a social/sexual eduction group. Individual #2's record included a second Written Informed Consent, dated 3/1/09, for one-to-one staffing and open hand deflection which included a Safety Plan. The Safety Plan included as part of the Written Informed Consent included the following 11 items: - No unsupervised contact with computers or the Internet. - No babysitting or being placed in positions of authority over people under the age of 18. - No contact with 1-900 numbers. - No unsupervised contact with family members except his mother and father. - No unsupervised contact with children under the age of 15.	W 124		

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W 124	Continued From page 9 - Monitoring when with peers if they were developmentally delayed. - No contact with sexually explicit material or pornography. - Adult supervision by an approved adult who was aware of his legal charges and the safety plan, twenty-four hours a day, seven days a week. - All adults in charge of supervising have knowledge of the safety plan. - Involvement in an adolescent sexual offender program specifically geared to individuals with developmental disabilities. - Involvement in a social/sexual education group. It was unclear why the Safety Plan information was different in the two consents. Further, there was no explanation regarding the conflicting information between the two consents (i.e., no unsupervised contact with individuals under the age of 15 verses under the age of 18). Additionally, Individual #2's record included a Court Decree which contained probationary conditions not addressed by, or consistent with, either safety plan as follows: - Abstain from the use and/or possession of intoxicating liquor, narcotic drugs, marijuana, or any other toxic substance, and submit to random drug screening at the discretion of his Probation Officer. No illegal substance shall be used or located at the residence at any time. - No contact with gang members or other juveniles or adults on probation and shall have no gang related paraphernalia, including items of clothing, belts, posters, etc. - No unsupervised contact with anyone one year younger than Individual #2. - Supervision shall be provided by an adult over twenty-one years of age who has knowledge of	W 124		

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W 124	Continued From page 10 his inappropriate sexual behavior. It was unclear why the safety plan did not contain or match conditions listed in Individual #2's probationary requirements. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., both the Administrator and QMRP stated they were not sure which safety plan was correct. When asked if the consent contained sufficient information to be informed, the QMRP stated it did not. b. Individual #2's Behavioral Assessment, dated 3/30/09, stated he engaged in the following: - Socially offensive behavior (rudeness, challenging/threatening talk, swearing). - Disruptive behavior (yelling slamming doors, complaining). - Uncooperative behavior (refusals). The assessment stated his socially offensive, disruptive and uncooperative behavior "appeared to be typical of an adolescent who's asserting their wants, needs and dislikes & trying to exercise some control over the events that occur within his life." The assessment stated the severity of his socially offensive, disruptive and uncooperative behaviors were not sufficient to warrant a formal objective or plan. Individual #2's record included a written informed consent, signed 3/19/09, which included behavioral levels and standards as follows: Level one: Full privileges, no behavioral restrictions. Maintaining level 1 for 3 months earned $50.00 purchase of chosen item. The standards for level one stated "All residents start	W 124		

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W 124	Continued From page 11 at level 1, without restrictions of privileges." Level two: No drink brought into JOG group, no drink during Social Class, no attendance in earned Saturday outing (does not prohibit regular community access). The standards for level two included "Cussing, yelling at staff or peers, spitting, refusing to clean room, refusing to get out of bed, general defiance, refusing to go to school. Must be free of level 2 behaviors for one week before moving to level 1." The written informed consent did not include information as to why the level 2 restrictions were necessary as his Behavioral Assessment stated socially offensive, disruptive and uncooperative behaviors were not sufficient to warrant a formal objective or plan. Level three: No drink brought into JOG group, no drink during Social Class, no attendance in earned Saturday outing (does not prohibit regular community access), no job opportunities, no Play Station, cannot participate as part of the house government. The standards for level three included "Minor property destruction, refusing to participate in programming, school misconduct, verbal sexual misconduct, elopement without leaving the property, threats to staff or peers, threats to self harm. Must be free of level 3 behaviors for one week before moving to level 2." The written informed consent did not include information as to why the level 3 restrictions were necessary as his Behavioral Assessment stated socially offensive, disruptive and uncooperative behaviors were not sufficient to warrant a formal objective or plan. Additionally, the Behavior Assessment did not include information related to	W 124		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	05/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 124	Continued From page 12 Individual #2 engaging in destruction of property, elopement or threats to harm himself as indicated in his behavioral level standards. Level four: No drink brought into JOG group, no drink during Social Class, no attendance in earned Saturday outing (does not prohibit regular community access), no job opportunities, no Play Station, cannot participate as part of the house government, no Lagoon trip. The standards for level four included "Aggression to staff or peers, major property destruction, physical sexual misconduct, elopement off of property, self harm, and compromise safety of self or others. Must be free of stated level 4 behaviors for one week before moving to level three." The written informed consent did not include information as to why the level 4 restrictions were necessary as his Behavioral Assessment stated socially offensive, disruptive and uncooperative behaviors were not sufficient to warrant a formal objective or plan. Additionally, the Behavior Assessment did not include information related to Individual #2 engaging in aggression to staff or peers, major property destruction, physical and sexual misconduct, elopement off of property, self harm, and compromising safety of self or others as indicated in his behavioral level standards. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated Individual #2's consent did not contain sufficient information to be informed. The facility failed to ensure Individual #2's Written Informed Consents contained sufficient and accurate information.	W 124	**W127 483.420 (a)(5) Protection of Client Rights** Please See Credible Letter dated July 1, 2009.	
W 127	483.420(a)(5) PROTECTION OF CLIENTS	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 127	Continued From page 13 RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to provide sufficient supervision and monitoring of individuals, and staff training and oversight, necessary to ensure the safety and welfare of individuals during the graveyard shift for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This failure resulted in the potential for individuals to sexually assault others within the facility and placed individuals in serious and immediate danger. The findings include: 1. Individual #1 - #7's IPPs, sexual histories, behavior management plans, and safety plans included the following: - Individual #1's 11/16/08 IPP stated he was an 18 year old male whose diagnoses included mild mental retardation, sexual abuse as a child, and adjustment disorder with disturbance of conduct. His IPP documented a history of perpetrating sexual abuse, and stated he engaged in inappropriate sexual contact. Individual #1's IPP stated he required one-on-one staffing except at school. Individual #1's IPP outlined a safety plan that included no unsupervised contact with family members except his mother and father, no unsupervised contact with children under the age of 15 years, close	W 127		

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W 127	Continued From page 14 monitoring when he was with his peers if they were developmentally delayed, and adult supervision by an approved adult who was aware of the changes and his safety plan, twenty-four hours/seven days a week. Individual #1's 12/5/06 Psycho-Sexual Assessment Update stated his risk level was moderate, and a Treatment Update, dated 4/26/07, his risk level remained guarded. Individual #1's BMP, dated 11/24/08, stated he was to have continuous monitoring on the graveyard shift and stated "A staff person is to be in the connecting bathroom monitoring his room at all times." - Individual #2's 6/3/08 IPP stated he was a 15 year old male whose diagnoses included Asperger's Syndrome, mild mental retardation, PDD and ADHD. His IPP stated he had a history of making sexual statements, inappropriate sexual touching, and incidents of inappropriate sexual conduct. His IPP contained no additional information regarding risk and supervision needs related to his sexual history. Individual #2's IPP stated he had a safety plan in place that was to be followed at all times which included no unsupervised contact with children under the age of 18 years and/or his sibling, close monitoring when he was with his peers if they were developmentally delayed, and adult supervision by an approved adult who was aware of his safety plan, twenty-four hours/seven days a week. Individual #2's Psychosexual Evaluation, dated 6/7/07, stated his risk level was at the cutoff	W 127		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 127	Continued From page 15 between the moderate and high range. The Evaluation stated Individual #2 was charged with sexually abusing seven neighborhood children. Individual #2's record also included a Court Decree documenting he had been convicted of three counts of lewd conduct with a minor under the age of sixteen. - Individual #3's 12/10/08 IPP stated he was an 18 year old male whose diagnoses included Asperger's Syndrome, ADHD, mild mental retardation, and mood disorder NOS. His IPP stated he had a history of sexually molesting his younger sister. His IPP stated he was to be line of sight at the facility and in the community. Individual #3's IPP outlined a safety plan that included no unsupervised contact with children under the age of 12 years and/or his siblings, close monitoring when he was with his peers if they were developmentally delayed, and adult supervision by an approved adult who was aware of his safety plan, twenty-four hours/seven days a week. Individual #3's Psycho-Sexual Assessment, dated 1/21/07, stated his risk level was low/moderate. The Assessment stated he had been charged with one count of lewd and lascivious conduct for molesting his 3 year old sister. The Assessment also stated Individual #3 had sexual contact with seven other individuals aside from his sister, including fondling his mother's breast when she was asleep and a peer that resided within the facility. - Individual #4's 4/22/09 IPP stated he was a 15 year old male whose diagnoses included reactive	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 127	Continued From page 16 attachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. His IPP stated he had engaged in accessing pornography, used undergarments of family members for masturbatory purposes, and engaged in peeking in at family members in their bedrooms and bathrooms. The IPP stated he had experienced personal physical, emotional and sexual abuse and witnessed physical, emotional and sexual abuse of his younger sister. The IPP state he was exposed to adults having intercourse in front of him, and the experiences made it difficult for him to understand appropriate relationships and sexual boundaries. Individual #4's record contained a safety plan, undated, that included no unsupervised contact with children under the age of 12 years and/or his siblings, close monitoring when with his peers if they were developmentally delayed, and adult supervision by an approved adult who had knowledge of his safety plan 24 hours a day. - Individual #5's 12/17/08 IPP stated he was a 17 year old male whose diagnoses included mild mental retardation, bipolar disorder II, major depressive disorder - recurrent, oppositional defiant disorder NOS, and ADHD. His IPP stated he had a history of sexually inappropriate behavior and had been charged with 5 counts of lewd and lascivious conduct with a neighbor boy. Individual #5's IPP stated he was to have line of sight staffing during all waking hours and continuous monitoring while sleeping. His BMP, dated 1/09, stated at night "A staff person is to be in the connecting bathroom monitoring his room at all times."	W 127		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 127	Continued From page 17 Individual #5's IPP outlined a safety plan that included no contact with family members without supervision, no unsupervised contact with children two or more years younger than he was, and adult supervision by an approved adult who was aware of the charges and his safety plan, twenty-four hours/seven days a week. - Individual #6's 2/25/09 IPP stated he was a 19 year old male whose diagnoses included antisocial personality disorder, reactive attachment disorder, consider: pedophilia, and mild mental retardation. His IPP stated he had been admitted to the facility from jail as a result of sexual misconduct with minor siblings. His IPP stated he had issues with inappropriate sexual behavior, inappropriate sexual comments, suicidal comments, and anxiety issues. Individual #6's IPP stated he had one-on-one staffing throughout waking hours and had exhibited inappropriate sexual behavior. Individual #6's record contained a safety plan, undated, that included no unsupervised contact with minor family members, no unsupervised contact with children under the age of 15 years and/or his siblings, close monitoring when he was with his peers if they were developmentally delayed, and adult supervision by an approved adult who was aware of the charges and his safety plan, twenty-four hours/seven days a week until reviewed further by the Court. Individual #6's Psychosexual Evaluation, dated 1/14/08, stated his risk level was high. The Evaluation stated he had sexually molested two of his younger siblings.	W 127		

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W 127	Continued From page 18 - Individual #7's 10/9/08 IPP stated he was a 19 year old male whose diagnoses included mild mental retardation, oppositional defiant disorder, post traumatic stress disorder, ADHD, and psychotic disorder NOS. His IPP stated he had a history of killing animals, serious aggression, threatening aggression, sexually abusing his younger sister, and re-offending during treatment. Individual #7's IPP and BMP, dated 3/1/09, stated he required continuous monitoring during the night to ensure he did not enter his peer's bedrooms. Individual #7's record contained a safety plan, undated, that included no unsupervised contact with children under the age of 13 years, close monitoring when he was with his peers if the were developmentally delayed, and adult supervision by an approved adult who was aware of his safety plan, twenty-four hours/seven days a week. Individual #7's Psychosexual Assessment Update, dated 11/7/06, stated his risk level was moderate. a. The facility consisted of four bedrooms. Bedroom #1 and bedroom #2 were accessed from the left side of the main hallway off of the living room and were connected by a shared bathroom. The hallway then angled to the right creating a shorter hallway which ended in a set of double doors leading to the back yard. Bedroom #3 and bedroom #4 were accessed from this shorter back hallway and were connected by a shared bathroom. Bedroom #1 was occupied by Individual #5, bedroom #2 was occupied by Individuals #2 and	W 127		

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W 127	Continued From page 19 #4, bedroom #3 was occupied by Individuals #6 and #7, and bedroom #4 was occupied by Individuals #1 and #3. During an observation on 5/1/09 from 5:25 - 6:30 a.m., the following concerns with staff location and monitoring of individuals were noted: - Staff A answered the door and was noted to be wearing headphones attached to a compact disc player she was carrying. After she answered the door, Staff A went into the hallway and sat with her back against the wall across from bedroom #2. - Staff B was noted to be lying face down in the hallway between bedroom #1 and bedroom #2. A portable DVD player was sitting on the floor approximately 10 inches from his face. Staff B was wearing headphones that were attached to the DVD player, and was watching a movie. - Staff C was in the back hallway between bedroom #3 and bedroom #4. She was lying on her left side with her head against two pillows and her back toward bedroom #4. The pillows were positioned against the wall across from bedroom #3 and bedroom #4, at the corner where the two hallways came together. Staff C was covered with a blanket and was watching a portable DVD player positioned approximately 12 inches from her face. She was wearing headphones attached to the DVD player and was watching a movie. When asked during the observation, Staff A stated graveyard staff were always located in the hallway, then stated one staff had sometimes been located in the bathroom between bedroom #3 and bedroom #4.	W 127		

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W 127	Continued From page 20 When asked during the observation, Staff B stated "What you seen this morning is the norm." He stated staff always used DVD players and headphones during the graveyard shift. Staff B stated graveyard staff had been located in the bathrooms connecting individuals' bedrooms when he first started working at for the facility. However, staff had been moved to the hallway about 8 months ago. When asked during the observation, Staff C stated she was unable to see Individuals #1, #3, and #7 from where she was observed, but stated she would be able to hear them if they were to get up. Staff C stated she could "hear around" her headphones. During a telephone interview on 5/1/09 from 8:47 - 9:00 a.m., the RSC stated there were always three staff on the graveyard shift. One staff remained outside of bedroom #2 where they could see Individual #2 and Individual #4. She stated the same staff would also be able to see Individual #6 and Individual #7 in bedroom #3. The RSC stated a second staff would be outside bedroom #4 and able to see Individual #1 and Individual #3. She stated the third staff would switch out with the first two staff in addition to performing cleaning tasks. The RSC stated graveyard staff were to monitor bedrooms and the laundry room, but were also allowed to watch portable DVD players while working. The RSC stated staff on the graveyard shift were previously positioned in the bathrooms that connected individuals bedrooms, but the practice was changed approximately one month ago based upon a recommendation from the Sex	W 127		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 127	Continued From page 21 Offender Treatment Specialist. The RSC stated positioning staff in the hallways allowed staff to monitor each other to ensure no inappropriate interaction occurred with individuals residing in the facility. When asked if the positions, location, and activities of staff observed on 5/1/09 at 5:25 a.m. was the expectation of the graveyard shift, the RSC stated it was not. During an interview on 5/1/09 from 10:35 - 11:10 a.m., the QMRP stated there should be three staff on shift, and staff should be located in the hallways monitoring through the open bedroom doors. The QMRP stated the connecting bathroom lights should be on. The QMRP stated the staff should be completing cleaning tasks while monitoring, and "mingling" to ensure all areas were covered. When asked where staff were to be located, the QMRP stated one staff should be in the hallway between bedroom #1 and bedroom #2. When asked how staff could ensure individuals were not moving around in the bedrooms, or going between bedrooms through the connecting bathroom, the QMRP stated the staff in the hallway should be performing checks in each room every 15 minutes. The QMRP stated the second staff should be in the hallway between bedroom #3 and bedroom #4 performing the same 15 minute checks. The QMRP stated the third staff should be doing cleaning and monitoring throughout the house. The QMRP stated she was not sure if the third staff did bedroom checks or not.	W 127		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 127	Continued From page 22 When asked when staff were moved from the bathrooms to the hallway, the QMRP stated she was not sure but it had been at least two months. The QMRP stated it was not clear who made the decision to move staff from the bathrooms to the hallway. When asked about the observation conducted on 5/1/09 at 5:25 a.m., the QMRP stated she would expect staff to be able to be up monitoring or moving. During a telephone interview on 5/1/09 from 9:07 - 9:37 a.m., the facility's contracted Sex Offender Treatment Specialist stated his recommendations regarding the graveyard staff were as follows: - One staff was to remain in each of the two connecting bathrooms between individuals' bedrooms in order to monitor activity in the bedrooms. - The third staff was to rove through all bedrooms checking on both individuals residing at the facility and staff in the bathrooms. - The staff that was roving should enter each bedroom at least twice every five minutes. The Sex Offender Treatment Specialist stated these recommendations had been made to the RSC. When asked if the positions, location, and activities of staff observed on 5/1/09 at 5:25 a.m. was how the graveyard staff should be monitoring individuals residing in the facility, the Sex Offender Treatment Specialist stated it was not. Given the needs and sexual histories of the individuals, it was not possible how staff positioned in the hallway could provide adequate	W 127		

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W 127	Continued From page 23 supervision during the graveyard shift. Without appropriate monitoring, the facility could not ensure individuals did not sexually assault or exploit other individuals residing at the facility. The facility failed to ensure individuals were adequately supervised on the graveyard shift. b. Six of the individuals residing at the facility were interviewed and stated the following regarding graveyard staffing: - During an interview on 4/30/09 from 3:25 - 3:55 p.m., Individual #6 stated he did not always get along with his roommate, Individual #7. He stated he could hear Individual #7 masturbating on the other side of the bedroom at night. Individual #6 stated Individual #7 had come over to his side of the bedroom at night and tried to touch him. Individual #6 stated he would tell Individual #7 "no" and tell him to go back to his side of the room. When asked where staff were at these times, Individual #7 stated they were in the hallway, and added staff were "technically" supposed to be in the bathroom watching. Individual #6 stated Individual #1 had come through the connecting bathroom and propositioned him multiple times. Individual #6 stated staff sat together in the hallway playing cards at night, and were not able to see Individual #1 come through the connecting bathroom into Individual #6's bedroom. He stated he would tell Individual #1 "no" at which point Individual #1 would pat him on the shoulder, tell him okay, and go back through the connecting bathroom to his own bedroom. He stated staff had not caught Individual #1, but this occurred "mostly every other night."	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	05/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 127	Continued From page 24 - During an interview on 4/30/09 from 4:20 - 4:35 p.m., Individual #7 stated he did not know where staff were during the graveyard shift. - During an interview on 4/30/09 from 4:45 - 5:00 p.m., Individual #1 stated the graveyard staff primarily stayed in the main living area of the facility and not in the area near individuals' bedrooms. He stated 2 graveyard staff were supposed to remain in the bathrooms that connected individuals' bedrooms in order to monitor, and 1 staff was to clean. Individual #1 stated graveyard staff were usually in the living room watching television. - During an interview on 4/30/09 from 5:05 - 5:25 p.m., Individual #4 stated he was not aware of where graveyard staff were because he was asleep each night before they arrived. - During an interview on 4/30/09 from 5:25 - 5:35 p.m., Individual #3 stated he believed graveyard staff remained in the hallway during their shift, one in the middle of the front hallway and one by the back door. - During an interview on 4/30/09 from 5:35 - 6:00 p.m., Individual #2 stated the graveyard staff were loud and disrupted his sleep. He stated when there were only two staff, one sat in the hallway where they could watch all four rooms, but he was not sure how one staff could watch all four rooms at one time. Three of the 6 individuals stated staff were located in the hallways or other areas of the facility during the graveyard shift. Without consistent and adequate monitoring, it would not	W 127		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

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W 127	Continued From page 25 be possible for staff to ensure individuals did not sexually exploit other individuals residing in the facility. c. During an interview on 4/27/09 from 12:45 - 1:10 p.m., the Administrator stated he had received no formal training regarding sex offender treatment. During an interview on 5/1/09 from 10:35 - 11:10 a.m., the QMRP stated she had no formal training regarding sex offender treatment. When asked about individuals' sex offender risk, the QMRP stated she could not list them off the top of her head but knew mostly who was high or moderate. The Administrator and QMRP did not have sufficient training to provide supervision and oversight to individuals or staff with regards to sex offender treatment. Without appropriate training and experience in working with sexual offenders, the facility would be unable to develop, implement, and monitor appropriate staffing patterns, training and supervision, and adequate treatment plans necessary to protect the individuals residing at the facility. The facility failed to ensure consistent and adequate monitoring of individuals, as well as staff training and supervision, was occurring on the graveyard shift. That failure placed Individuals #1 - #7 in serious and immediate danger. Note: The facility submitted an immediate plan of correction which included the following: - Starting 5/1/09, all graveyard staff were required	W 127		

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W 127	Continued From page 26 to attend training to ensure clear understanding of client safety and supervision. - No graveyard staff were to work a shift without the appropriate training, including newly hired staff, fill-in staff, and on-call staff. - Graveyard staff were prohibited from using personal electronics, video games, DVD players, and audio devices while on shift. - Graveyard staff were prohibited from lying on the floor, sleeping, or engaging in any activity that would decrease their ability to observe individuals residing in the facility. - Graveyard staff were prohibited from performing cleaning duties. - One staff was to be located in each of the two bathrooms that connected individuals' bedrooms. Those staff were to be awake and in an upright sitting or standing position monitoring the bedrooms of the individuals. - A third staff was to be roving through the home, checking individuals and staff by visually seeing "flesh" of each individual. A routine was established that provided each room was entered twice every five minutes. - The third staff documented each individual check. - The graveyard staff would change positions every 30 minutes, (i.e., bathroom staff verses roving staff). - For a period of three weeks beginning May 1 2009, a supervisory staff would work the graveyard shift as a fourth staff to provide on-site training and monitoring of graveyard staff. Supervisory staff included the Administrator, QMRP, RSC, Leadworker, and A.M. In Charge. An observation was completed at the facility on 5/1/09 from 10:53 - 11:40 p.m. During that time, it was noted that one staff was in each of the two	W 127		

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W 127	Continued From page 27 bathrooms connecting the individuals' bedrooms. No electronic devices were noted to be present. A third staff, who was also the Leadworker, was roving through the home, holding a notebook, documenting upon entering each bedroom. The Leadworker stated he was filling in for a direct care position. Also present were the QMRP, RSC, and A.M. In Charge. The two direct care staff, QMRP, RSC, and A.M. In Charge were interviewed. All were able to explain the monitoring changes documented in the plan of correction. All stated a training had taken place prior to the beginning of the graveyard shift regarding the supervision requirements and expectations on the graveyard shift. The Leadworker, A.M. In Charge, QMRP, and RSC all stated no staff was to be allowed to work without prior training, including fill-in, on-call, and newly hired staff. Based upon interview and observation, the Immediate Jeopardy was abated.	W 127		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on review of the facility's policies and procedures, record review, and staff interview it was determined the facility failed to adequately design, implement and monitor policies and procedures to prohibit abuse, neglect, or mistreatment for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in	W 149	**W149 483.420 (d)(1) Staff Treatment of Clients** Please See Credible Letter dated July 1, 2009.	

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 149	Continued From page 28 individuals' needs being neglected by staff and the potential for individuals to be subjected to on going individual to individual abuse, exploitation, mistreatment, and self harm. The findings include: 1. The facility's Abuse, Neglect, Mistreatment, and Injuries of an Unknown Source policy, revised 2/10/09, defined neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The facility housed seven males, age 15 to 19, all of whom had sexually deviant behavior. Additionally, 5 of those individuals (Individuals #1, #4, #5, #6, and #7) engaged in suicidal threats. The individuals were not provided with adequate staff supervision necessary to ensure they were not subjected to ongoing abuse, mistreatment, and exploitation from other individuals and themselves as follows: a. The facility's policy titled Suicide Guidelines, dated 10/16/08, stated "As employees you are required to actively strive to prevent and/or report any incidents of residents threatening or attempting to harm themselves." As stated, staff had a choice to either prevent or report incident, but were not required to do both. Under the section titled Procedures, it stated an assessment would be conducted within 2 hours of a threat. There were no directions on what to do within that time frame. The policy stated the individual would be "line of sight" until the Administrator or designee reviewed the assessment. The policy did not define "line of sight" or what to do to ensure the	W 149		

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W 149	Continued From page 29 individual's safety. The policy stated "If a resident is having thoughts of hopelessness, monitor them closely. If they continue to display feelings of hopelessness for two consecutive hours or more, contact the Administrator and/or designee immediately." No less than nine direct care staff were interviewed over the course of the survey. All staff stated they had not received training related to hopelessness. The policy stated "If a resident is showing signs of depression for two consecutive hours or sporadically for more than one day, contact the Administrator and/or designee immediately." No less than nine direct care staff were interviewed over the course of the survey. All staff stated they had not received training related to depression. The policy stated "If a resident displays signs of suicide ideation maintain line of sight and contact the Administrator and/or designee immediately." The policy did not define line of sight. The policy stated anytime a statement or gesture was made, staff were to place them on line of sight and complete a room search. The policy did not contain directions on what to do with potentially dangerous items that were found. A body search was not included in the policy. The policy stated anytime a resident attempted suicide, they were to be placed on line of sight for 24 hours and a suicide checklist was to be completed. The policy did not contain clear directives on what to do during that 24 hour time frame.	W 149		

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W 149	Continued From page 30 Under the section titled Suicide Watch Guidelines, it stated anytime an individual "...threatens or attempts suicide or gives other indications of suicidal tendency they will be placed on a suicide watch ..." The watch was to last for 24 hours, the individual's room was to be searched, a body search performed, and "The resident will be line of sight or one to one staffing based on Administrator instruction." The policy did not define "line of sight" or "one to one." The policy stated in order for the watch to be removed, the facility's Licensed Professional Counselor would assess the individual. When asked during an interview on 4/27/09 from 11:35 - 11:55 am., the Licensed Professional Counselor stated he assessed individuals by phone based on questions asked by staff and had not been to the facility to assess individuals. The facility failed to ensure the Suicide Guidelines policy was sufficiently developed to ensure staff provided adequate supervision to individuals experiencing suicidal ideation. Without adequate policy development and implementation, the facility's ability to ensure the individuals needs were not neglected was significantly impeded. b. Refer to W127 as it relates to the facility's failure to ensure staff were provided with necessary training to adequately develop, implement and monitor sexual offender treatment policies and interventions. This resulted in the individuals' supervision needs being neglected and the potential for individuals to be subjected to on-going sexual abuse, exploitation and mistreatment from other individuals.	W 149		

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W 149	Continued From page 31 The facility failed to ensure policies and procedures were adequately designed, implemented and monitored to prohibit neglect related to individuals monitoring, supervision, and treatment needs.	W 149	**W153 483.420 (d)(2) Staff Treatment of Clients** Please See Credible Letter dated July 1, 2009.	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of investigations, record review and staff interview it was determined the facility failed to ensure all allegations of abuse were immediately reported to the administrator for 1 of 1 individuals (Individual #6), for whom abuse was alleged. This resulted in the potential for on-going abuse to occur. Findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries of an Unknown Source policy, revised 2/10/09, stated employees were required to "actively strive to prevent and/or report any incidents or alleged incidents of abuse, neglect, mistreatment, or injuries of an unknown source to your Administrator immediately." Additionally, the policy defined Neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Individual #6's 2/25/09 IPP stated he was a 19	W 153		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 153	Continued From page 32 year old male whose diagnoses included antisocial personality disorder, reactive attachment disorder, and mild mental retardation. His IPP stated he had a history of inappropriate sexual behavior, was receiving sexual offender treatment, and had an objective to reduce incidents of invading other's personal space. An Investigation, dated 12/18/08, documented a graveyard staff was observed hand in hand with Individual #6 during the graveyard shift on 12/13/08, and the incident "looked suspicious." The "Incident Reporting" section of the Investigation documented the Administrator was notified of the incident on 12/13/08 at 1:15 p.m. The document did not contain information that the Administrator was immediately notified of the incident. Additionally, attached to the investigation was a staff statement that documented the staff observed hand in hand with Individual #6 had been found in November 2008, lying with Individual #6 on his bed watching a DVD. The investigation did not contain information that the November 2008 incident had been reported to the Administrator or investigated. Given the nature of Individual #6's sexual history and sexual offender treatment, it was not clear why the incident was not immediately reported to the Administrator for investigation. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Administrator stated no additional documentation regarding notification existed and he did not believe notification had taken place prior to the 1:15 p.m. time documented in the 12/18/08 investigation. The	W 153		

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W 153	Continued From page 33 Administrator stated he did not deem the event as an "allegation" that required investigation, but rather as a "staff training" issue. However, due to Individual #6's status as a vulnerable adult, sexual offender history, and on-going sex offender treatment needs, and given the staff's position of authority over Individual #6, the staff's personal interactions (i.e. hand holding and lying with Individual #6 on his bed) should have been immediately reported to the Administrator. The facility failed to ensure all allegations, including those of potential neglect and abuse, were immediately reported to the Administrator.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of investigations, record review and staff interview it was determined the facility failed to ensure all allegations of abuse were thoroughly investigated for 1 of 1 individuals (Individual #6) for whom alleged abuse was investigated. This resulted in an absence of appropriate investigation and follow up to the incidents. The findings include: 1. Individual #6's 2/25/09 IPP stated he was a 19 year old male whose diagnoses included antisocial personality disorder, reactive attachment disorder, and mild mental retardation. His IPP stated he had a history of inappropriate sexual behavior, was receiving sexual offender	W 154	**W154 483.420 (d)(3) Staff Treatment of Clients** Please See Credible Letter dated July 1, 2009.	

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 154	Continued From page 34 treatment, and had an objective to reduce incidents of invading other's personal space. An Investigation, dated 12/18/08, documented a graveyard staff was observed hand in hand with Individual #6 during the graveyard shift on 12/13/08, and the incident "looked suspicious." The investigation documented the staff alleged to be holding hands with Individual #6 was interviewed and stated the individual grabbed her hand, which lasted about 30 seconds and she was not sure why he had done so. The staff stated she believed Individual #6 had a crush on her. The staff was asked about previous training on maintaining personal space based upon another incident involving Individual #6. The staff stated she had not received formal training, but had been asked to sign a paper that said to make sure she was maintaining personal space with the individuals residing at the facility. The staff stated the incident in question had crossed the boundary of maintaining personal space. The Investigation further stated "All of the residents at [name of facility] were interviewed by [Sex Offender Treatment Specialist]... The resident in this incident stated that he was grabbing some headphones out of her hand and listening to the song/movie that was playing. He did not feel that anything inappropriate had occurred." Attached to the Investigation were written statements from 10 direct care staff and the RSC, as well as the 7 individuals residing at the facility. The 7 individuals denied having seen inappropriate actions by the staff in question, and three of the direct care staff documented they had not witnessed inappropriate actions. Seven of the	W 154		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 154	Continued From page 35 direct care staff and the RSC documented concerns as follows: - One staff documented she had witnessed the staff in question laying on a bed with Individual #6, watching a DVD, in November 2008. - A second staff documented she had found the staff in question laying on Individual #6's bed with him watching a movie. The staff did not document when the incident occurred. - A third staff documented they were not on shift at the time of the hand holding incident, but had noticed the staff in question and Individual #6 getting close to each other, and documented the staff did not request Individual #6 maintain appropriate space. - A fourth staff documented observing the staff in question getting too close to individuals residing in the facility, not cuing individuals to maintain appropriate space, Individual #6 and Individual #5 being "very concerned" when the staff in question was not working a shift, and that the staff in question volunteered to work the graveyard shift in order to be with Individual #6 when he was upset. - A fifth staff documented they had walked into the bathroom and found Individual #6 and the staff in question holding hands, at which time Individual #6 and the staff in question quickly pulled away from each other. - A sixth staff documented the staff in question had been seen "too close" with Individual #6, and documented other staff had mentioned to her the staff in question had issues maintaining space with the individuals residing at the facility. - A seventh staff documented the staff in question had been observed up past midnight watching TV with Individual #6, but did not document when or where the incident occurred. - The RSC documented staff had come to her	W 154		

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W 154	Continued From page 36 regarding the concerns with space issues between the staff in question and Individual #6, including an issue in November 2008 when the staff in question was "caught" laying on Individual #6's bed watching a movie. The Investigation did not include documentation that staff had been interviewed to clarify information contained within the staff statements (what was meant by "too close," dates and times of incidents, etc.). Additionally, the Investigation did not include documentation that additional concerns identified in the statements had been addressed (i.e., concerns regarding the staff in question's failure to maintain appropriate personal space with individuals residing at the facility, failure of staff to report concerns to Administrative staff at the time of occurrence, or investigation of the November 2008 incident where the staff in question was found lying on a bed with Individual #6). Without thorough investigation of the identified concerns, the facility would be unable to identify potential grooming behavior by Individual #6 given the nature of his history and sexual offender treatment. Additionally, the facility would be unable to ensure staff received needed training regarding appropriate reporting and conduct with sexual offenders. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Administrator stated his focus had been on the incident of hand holding and what needed to happen with the staff in question as a result. The Administrator stated he did not feel the other concerns identified were issues that required investigation.	W 154		

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W 154	Continued From page 37 The facility failed to ensure incidents of concern were thoroughly investigated.	W 154	**W157 483.420 (d)(4) Staff Treatment of Clients** Please See Credible Letter dated July 1, 2009.	
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on review of investigations, record review, and staff interview it was determined the facility failed to ensure appropriate corrective action was taken for 1 of 1 individuals (Individual #6) for whom an investigation was completed. This resulted in a lack of training with regards to immediate reporting of potential abuse, neglect, and mistreatment. The findings include: 1. Individual #6's 2/25/09 IPP stated he was a 19 year old male whose diagnoses included antisocial personality disorder, reactive attachment disorder, and mild mental retardation. His IPP stated he had a history of inappropriate sexual behavior, was receiving sexual offender treatment, and had an objective to reduce incidents of invading other's personal space. An Investigation, dated 12/18/08, documented a graveyard staff was observed hand in hand with Individual #6 during the graveyard shift on 12/13/08, and the incident "looked suspicious." The investigation documented the staff alleged to be holding hands with Individual #6 was interviewed and stated the individual grabbed her hand, which lasted about 30 seconds and she was not sure why he had done so. The staff stated she believed Individual #6 had a crush on her. The staff was asked about previous training	W 157		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

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W 157	Continued From page 38 on maintaining personal space based upon another incident involving Individual #6. The staff stated she had not received formal training, but had been asked to sign a paper that said to make sure she was maintaining personal space with the individuals residing at the facility. The staff stated the incident in question had crossed the boundary of maintaining personal space. The "Recommendations" section of the Investigation stated "Because of the previous training that occurred on maintaining personal space and boundaries with this same resident and client, it was determined that [name of staff] should be moved to another facility in order to maintain safety." No additional recommendations were made. However, written statements attached to the Investigation documented no less than seven staff had known concerns regarding the staff in question's conduct with individuals in the facility since November 2008 when the staff in question was found lying on a bed with Individual #6 watching a DVD. The Investigation did not include any additional information such as training provided to other staff regarding personal space issues, potential grooming issues related to sex offender treatment, or immediate reporting of concerns to Administrative staff. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Administrator stated his focus had been on the incident of hand holding and what needed to happen with the staff in question. The Administrator stated he did not feel	W 157		

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W 157	Continued From page 39 the other concerns identified were issues. The facility failed to ensure appropriate corrective action was taken for all concerns identified in the 12/18/08 Investigation.	W 157	**W158 483.430 Facility Staffing** Please See Credible Letter dated July 1, 2009.	
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observation, review of the facility's policies and procedures, record review, and individual and staff interviews it was determined the facility failed to ensure competent, trained staff were available to provide supervision and meet the behavioral needs of the individuals residing in the facility. This resulted in a lack of client protection and a lack of appropriate behavioral services being provided to the individuals. The findings include: 1. Refer to W159 as it relates to the failure of the facility to ensure the QMRP's service design and delivery provided each individual with protective and behavioral services to meet their needs. 2. Refer to W166 as it relates to the failure of the facility to ensure professional program staff worked with nonprofessional and other professional program staff who worked with the individuals residing in the facility. 3. Refer to W169 as it relates to the failure of the facility to ensure professional program staff participated in on-going staff development and training with other professional and nonprofessional staff members.	W 158		

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W 158	Continued From page 40 4. Refer to W191 as it relates to the failure of the facility to ensure staff demonstrated the skills and competencies necessary to address individuals' behavioral needs.	W 158		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. That failure resulted in individuals not receiving the necessary services, supports, and training required to meet their health, safety, and behavioral needs. The findings include: 1. Refer to W120 as it relates to the facility's failure to ensure the QMRP's service design and delivery provided each individual with appropriate outside services to meet their needs. 2. Refer to W124 as it relates to the facility's failure to ensure the QMRP provided sufficient information to parents/guardians on which to base consent decisions. 3. Refer to W127 as it relates to the facility's failure to ensure the QMRP ensured sufficient staff training and oversight, and adequate monitoring and supervision of individuals during the graveyard shift, which resulted in individuals	W 159	**W159 483.430 (a) Qualified Mental Retardation Professional** Please See Credible Letter dated July 1, 2009.	

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W 159	Continued From page 41 being found in serious and immediate jeopardy. 4. Refer to W166 as it relates to the facility's failure to ensure the QMRP ensured professional program staff worked with nonprofessional and other professional program staff who worked with the individuals residing in the facility. 5. Refer to W169 as it relates to the facility's failure to ensure the QMRP ensured professional program staff participated in on-going staff development and training with other professional and nonprofessional staff members. 6. Refer to W191 as it relates to the facility's failure to ensure the QMRP ensured staff demonstrated the skills and competencies necessary to address individuals' behavioral needs. 7. Refer to W210 as it relates to the facility's failure to ensure the QMRP ensured assessments were conducted for an individual within 30 days of admission. 8. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral status and needs. 9. Refer to W227 as it relates to the facility's failure to ensure the QMRP ensured individuals' IPPs included objectives to meet their behavioral needs. 10. Refer to W234 as it relates to the facility's failure to ensure the QMRP ensured individuals' behavior plans included sufficient direction to	W 159		

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W 159	Continued From page 42 staff. 11. Refer to W273 as it relates to the facility's failure to ensure the QMRP ensured individuals were not allowed to discipline each other, except as part of an organized system of self-government, as set forth in facility policy. 12. Refer to W289 as it relates to the facility's failure to ensure the QMRP ensured techniques used to manage individuals' maladaptive behaviors were incorporated into program plans. 13. Refer to W312 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. The cumulative effect of these negative facility practices significantly impeded the ability of the facility to provide services to meet the health, safety, and behavioral needs of individuals residing in the facility.	W 159		
W 166	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Professional program staff must work with paraprofessional, nonprofessional and other professional program staff who work with clients. This STANDARD is not met as evidenced by: Based on observation, record review, and interviews with staff and the Sex Offender Treatment Specialist, it was determined the facility failed to ensure professional staff worked	W 166	**W166 483.430 (b)(1Professional Program Services** Please See Credible Letter dated July 1, 2009.	

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 166	Continued From page 43 with other professionals and direct care staff sufficiently to ensure the implementation and monitoring of services required for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in a lack of thorough assessment of the individuals' environment, program overview, and staff training in relation to sexual offender treatment. The findings include: 1. The facility housed seven males, age 15 to 19, all of whom had sexually deviant behavior that involved children. The facility consisted of four bedrooms. Bedroom #1 and bedroom #2 were accessed from the left side of the main hallway off of the living room and were connected by a shared bathroom. The hallway then angled to the right creating a shorter hallway which ended in a set of double doors leading to the back yard. Bedroom #3 and bedroom #4 were accessed from this shorter back hallway and were connected by a shared bathroom. Bedroom #1 was occupied by Individual #5, bedroom #2 was occupied by Individuals #2 and #4, bedroom #3 was occupied by Individuals #6 and #7, and bedroom #4 was occupied by Individuals #1 and #3. During an observation on 4/29/09 from 4:18 - 4:50 p.m., the following items were noted: - The bedroom shared by Individual #1 and Individual #3 contained a movie picture with young children. - The wall by Individual #6's bed was covered with pictures that included young children. When asked about the pictures, staff present stated the pictures were of family and friends of Individual #6. - The wall by Individual #2's bed included pictures	W 166		

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W 166	Continued From page 44 of his family including a younger sibling. During a telephone interview on 5/1/09 from 9:07 - 9:37 a.m., the facility's contracted Sex Offender Treatment Specialist stated he had been to the facility, but only in the dining area and the office located in the garage. He stated he had not assessed the environment or individuals' bedrooms. He stated he was not aware of what pictures individuals had on their bedroom walls, or of pictures that were on the wall in the main living areas of the facility. When asked if individuals should have pictures of their victims on the wall, the Sex Offender Treatment Specialist stated he would highly recommend that individuals did not. Without being physically present in the facility, it would not be possible for the Sex Offender Treatment Specialist to adequately assess individuals' environment in relation to the sex offender treatment. The facility failed to ensure the Sex Offender Treatment Specialist worked in coordination with the facility's staff to ensure the environment met the needs of the individuals. 2. The facility's policy related to Sex Offender Treatment, dated 5/30/08, consisted of four sections: 1) Initial Assessment of Potential and Current Risk, 2) Implementation of Objectives, 3) Thinking Errors, Problem Solving, and Tracking Maladaptive Behaviors, and 4) Peer Accountability and Support. - The policy stated the individual "may" be line of sight or arm's length during the first 30 days. The policy did not define line of sight supervision.	W 166		

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W 166	Continued From page 45 - The policy stated the individual "may" be on fifteen minute visual checks while alone in their room. However, it was not clear, based on the needs of the individuals residing at the facility and the layout of individuals' bedrooms and bathrooms, how 15 minute checks would be sufficient to ensure no exploitation occurred. - Under the section titled Implementation of Objectives, it stated objectives were to be developed based on the individual's assessed needs to include " ...sexual, social, and behavioral boundaries and offense recognition objectives." However, given the QMRP and IDT's lack of training regarding sex offender treatment, it would not be possible to ensure this section of the policy was implemented. The policy was not sufficiently developed such that it contained directions to incorporate the systemic approach in individuals' plans. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Behavior Specialist stated she had written the Sex Offender Treatment policy, but stated she had not received training regarding sex offender treatment. The facility failed to ensure the Sex Offender Treatment Specialist worked with other professional staff at the facility in the development of the policy related to Sex Offender Treatment. 3. Refer to W127 as it relates to the facility's failure to ensure the Sex Offender Treatment Specialist worked with the facility's professional and graveyard staff to ensure adequate oversight and monitoring of individuals on the graveyard	W 166		

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W 166	Continued From page 46 shift. 4. Refer to W169 as it relates to the facility's failure to ensure the Sex Offender Treatment Specialist worked with the facility's professional staff to ensure they were sufficiently trained in sex offender treatment. 5. Refer to W191 as it relates to the facility's failure to ensure the Sex Offender Treatment Specialist worked with the facility's professional, para-professional, and direct care staff to ensure staff were sufficiently and comprehensively trained in the treatment of sex offenders. The facility failed to ensure the Sex Offender Treatment Specialist worked sufficiently with the Administrator, QMRP, Behavior Specialist, RSC, and direct care staff to ensure the implementation and monitoring of services to meet individuals' needs.	W 166		
W 169	483.430(b)(4) PROFESSIONAL PROGRAM SERVICES Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure competent, trained staff were available to provide necessary services and supports to protect the health and safety for 7 of 7 individuals (Individuals #1 - #7) residing at the facility. This resulted in a lack of client protection being provided to the individuals.	W 169	**W169 483.430 (b)(4) Professional Program Services** Please See Credible Letter dated July 1, 2009.	

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W 169	Continued From page 47 The findings include: 1. The facility housed seven males, age 15 to 19, all of whom had sexually deviant behavior. All seven individuals participated in a sex offender treatment program. During an interview on 4/27/09 from 12:45 - 1:10 p.m., the Administrator stated he had received no formal training regarding sex offender treatment other than what he had picked up from the current and former Sex Offender Treatment Specialists. The QMRP, who was present during the interview, stated she had received no formal training regarding sex offender treatment, but she had a "couple of books" on her desk that she had been able to browse through. The QMRP stated she was responsible for writing the training programs for the individuals residing in the facility, including behavior management programs. During an interview on 5/4/09 from 1:00 - 3:45 p.m., the Behavior Specialist stated she was responsible for completing individuals' Behavioral Assessments. The Behavior Specialist stated she had not received any training specific to sex offender treatment. Without specific training and understanding of sex offenders, their treatment, and how it impacted their needs within the facility and community, it would not be possible for the facility to ensure the professional staff had the knowledge and skills necessary to develop and implement programing to meet individuals' specific needs. The facility failed to ensure the Administrator,	W 169		

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W 169	Continued From page 48 QMRP, and Behavior Specialist received adequate training. 2. The facility housed seven males, age 15 to 19, all of whom had sexually deviant behavior. Additionally, 5 of those individuals (Individuals #1, #4, #5, #6, and #7) engaged in suicidal threats. During an interview on 4/27/09 from 12:45 - 1:10 p.m., the Administrator and QMRP both stated they had been through a training with the LPC on how to fill out a suicide assessment form. The form had been developed by the LPC and was not a standardized assessment. Both stated they had received no additional training regarding suicide, depression, or anxiety issues. During a telephone interview on 4/27/09 from 11:30 - 11:55 a.m., the LPC stated he had developed the suicide assessment form off various other suicide assessments. The LPC stated he had trained staff, including the Administrator and QMRP, to complete the form with individuals residing at the facility. The LPC stated he had not provided any additional training to the facility regarding mental health issues. Without sufficient training in the identification and tracking of mental health symptoms, it would not be possible for the QMRP to ensure individuals needs were met.	W 169		
W 191	483.430(e)(2) STAFF TRAINING PROGRAM View in-service training as a dynamic growth process. It is predicated on the view that all levels of staff can share competencies which enable the individual to benefit from the consistent, wide-spread application of the interventions required by the individual's particular	W 191	**W191 483.430 (e)(2) Staff Training Program** Please See Credible Letter dated July 1, 2009.	

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W 191	Continued From page 49 needs. In the final analysis, the adequacy of the in-service training program is measured in the demonstrated competencies of all levels of staff relevant to the individual's unique needs as well as in terms of the "affective" characteristics of the caregivers and the personal quality of their relationships with the individuals. Observe the staff's knowledge by observing the outcomes of good transdisciplinary staff development (i.e., in the principles of active treatment) in such recommended competencies as: · Respect, dignity, and positive regard for individuals (e.g., how staff refers to individuals, refer to W150); Use of behavioral principles in training interactions between staff and individuals; · Use of developmental programming principles and techniques, e.g., functional training techniques, task analysis, and effective data keeping procedures; · Use of accurate procedures regarding abuse detection and prevention, restraints, medications, individual safety, emergencies, etc.; · Use of adaptive mobility and augmentative communication devices and systems to help individuals achieve independence in basic self-help skills; and · Use of positive behavior intervention programming. §483.430(e)(2) Probes	W 191		

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W 191	Continued From page 51 on sex offender treatment. One of the 9 staff stated she had received no training regarding sex offender treatment. Three of the 9 staff stated they had been through an extended sex offender training program under the previous Administrator two or more years ago. The training had consisted of 8 hours presented over 8 weeks. All three staff stated they had received no additional training. Five of the staff stated they had received training from the RSC which consisted of reading a two page bulleted document and being asked to sign a sheet indicating they understood the two page document. When asked during an interview on 4/27/09 from 12:45 - 1:10 p.m., both the Administrator and QMRP stated they had received no formal training regarding sex offender treatment. Both stated the facility's RSC completed training with new staff regarding sex offender treatment and individual's needs. When asked during a telephone interview on 5/1/09 from 8:47 - 9:00 a.m., the RSC stated she provided training to new staff regarding sex offender treatment using a two page bulleted document she had created from a test used in the facility's former training course for sex offender treatment. The training consisted of having new staff review the two page document and sign a document stating they understood the information. The RSC stated staff previously were required to listen to an audio tape made by the former Sex Offender Treatment Specialist, but the audio tape had been destroyed in	W 191		

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W 191	Continued From page 50 Does the staff training program reflect the basic needs of the individuals served within the program? Does observation of staff interactions with individuals reveal that staff know how to alter their own behaviors to match needs and learning style of individuals served? For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff were able to demonstrate cross-cutting skills and competencies related to behavioral needs for 7 of 7 individuals (Individuals #1 - #7) whose IPPs, sexual histories, behavior management plans, and safety plans were reviewed. This resulted in an inability of staff to consistently recognize and intervene when individuals displayed behavior related to their sex offender status and mental health diagnoses. The findings include: 1. The facility housed seven males, age 15 to 19, all of whom had sexually deviant behavior. All seven individuals received sex offender treatment. Additionally, 5 of those individuals (Individuals #1, #4, #5, #6, and #7) engaged in suicidal threats. a. During the course of the survey, no less than 9 direct care staff were interview regarding training	W 191		

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W 191	Continued From page 52 December 2008. The two page training document was reviewed and included the following: "The residents at [name of facility] all have sexual deviancy behaviors. Some of them are opportunist and if given the chance to offend again they will. It is extremely important that the staff at [name of facility] is ensuring that they are following the residents safety plan daily and behavior management plans at all time. (See floor book). The residents will not be successful if the staff is not providing the residents 24/7 sexual offender treatment. All the residents need staff to role model healthy relationships, friendships, as well as boundaries. Sexual offender treatment is shown by some following staffing ratios (one-to-one, and line of sight staffing) dressing appropriately, communicating appropriately, and ensuring that everyone is respecting others personal space." Additionally, the document provided brief descriptions of three types of touch (good, bad, and secret), stated there were two types of sexual acts (hands on and hands off) but gave no descriptions, bulleted eight steps in an "Offense Cycle" but provided no explanations or definitions, and bulleted five steps in an "Anger Cycle" but provided no explanations or definitions. The document provided brief statements that staff were not to discuss their personal life, were to write behavior logs if an individual engaged in a behavior and provided one line statements describing one-on-one staffing in the community. The document provided brief, one line descriptions of four "Thinking Errors" that included unique, grooming, silent power, and "my	W 191		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 191	Continued From page 53 way." The document did not provide sufficient information to train staff on how to identify individuals' behavior as sexually deviant, or provide information as to how staff were to respond if an individual engaged in such behavior. Further, the document did not provide information regarding how staff were to provide and maintain oversight and supervision of the individuals given their sexual histories. Without sufficient training, staff would not be able to ensure individuals' needs with regards to their sex offender training would be met. b. During the course of the survey no less than 9 direct care staff were interviewed regarding their training on suicidal ideation and mental illness. One of the 9 staff stated she had been through a training course with the facility's Sex Offender Treatment Specialist, who was also the LPC, on completion of a suicide assessment. The assessment consisted of a list of questions complied by the LPC which staff were to ask the individual. The staff stated she had received no specific training regarding hopelessness, depression, or anxiety. The staff stated she was not aware of individuals' mental illness diagnoses. Three of the 9 staff stated they had received a packet of information during orientation which they were to read and sign a sheet indicating they understood the information. All three of the staff stated they had not received specific training regarding hopelessness, depression, or anxiety. All three of the staff stated they were not aware of individuals' mental illness diagnoses. Two of the	W 191		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 191	Continued From page 54 3 staff stated they believed one of the individuals sometimes became depressed. Five of the nine staff stated they had received no training regarding suicidal ideation, mental illness, hopelessness, depression, or anxiety. All five stated they were not aware of individuals' mental illness diagnoses. Without sufficient training regarding suicidal ideation and mental illness, including signs and symptoms, it would not be possible for staff to adequately meet individuals mental health needs. The facility failed to ensure staff were able to demonstrate cross-cutting skills and competencies related to the individuals' sexually inappropriate behaviors and mental illness.	W 191		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were conducted within 30 days of admission for 1 of 1 individual (Individual #4) admitted to the facility within the last 6 months. This resulted in insufficient information being available regarding an individual's sexual risk to self or others. The findings include: 1. Individual #4's IPP, dated 4/22/09, documented	W 210	**W210 483.440 (c)(3)** Individual Program Plan 1. Preferred Community Homes and Belmont Management signed a new contract dated 6/1/2009, which outlined the expectation for the LPC to complete the Risk Assessment. 2. PCH adopted a double layer check system, utilizing an AQMRP and a QMRP to assure all assessments are completed as needed. The QMRP will be completing quarterly quality assurance client book reviews, which include a checklist to assure all needed assessments are completed and in the file. 3. AQMRP/QMRP will review all other Milliken Client Records to assure Sexual Risk Assessments have been completed, in the instance that they have not been completed, they will be. 4. The QMRP/AQMRP will be responsible to assure monitoring and compliance with W210	8/1/09

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 210	Continued From page 55 a 15 year old male diagnosed with pervasive developmental disorder NOS, reactive detachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. He was admitted to the facility on 3/26/09. Individual #4's records contained an Idaho Standard Mental Health Assessment Report, dated 2/19/09, which documented he was seeing a counselor for issues with pornography, stealing his mother and sister's underwear, and using them to masturbate and using his deceased grandmother's prosthetic breasts in a "sexual manner." The facility's policy related to Sex Offender Treatment, dated 5/30/08, stated "Upon admittance to [name of facility] - Sexual Offender treatment program, the Inter-disciplinary Treatment Team will assess the client's current and potential risk to re-offend based on the circumstances and history of his or her admittance. This initial assessment will take place within the first 30-days of admittance date." However, Individual #4's record did not include information related to his risk level (i.e., a psycho-sexual assessment). A lack of a clear assessment for Individual #4's sexual risk to himself or others would significantly impede the facility's ability to develop appropriate treatment and guidelines for his care. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated that a psychosocial risk assessment had not been completed for Individual #4. The facility failed to ensure a psychosexual risk	W 210		

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W 210	Continued From page 56 assessment was completed within 30 days of admission for Individual #4.	W 210	**W214 483.440 (c)(3)(iii) Individual Program Plan**	
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 3 of 7 individuals (Individuals #2, #4, and #5) whose behavioral assessments and/or psycho-sexual assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #2's 6/3/08 IPP stated he was a 15 year old male diagnosed with Asperger's Syndrome, mild mental retardation, PDD and ADHD. His record include court documents, dated 5/22/07, which stated he was on probation for committing crimes of a sexual nature. Individual #2's Behavioral Assessment, dated 3/30/09, stated he engaged in the following: - Socially offensive behavior (rudeness, challenging/threatening talk, swearing). - Disruptive behavior (yelling slamming doors, complaining). - Uncooperative behavior (refusals). The assessment stated his socially offensive, disruptive and uncooperative behavior "appeared to be typical of an adolescent who's asserting their wants, needs and dislikes & trying to	W 214	Please see Credible Letter dated July 1, 2009	

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W 214	Continued From page 57 exercise some control over the events that occur within his life." The assessment stated the severity of his socially offensive, disruptive and uncooperative behaviors were not sufficient to warrant a formal objective or plan. However, his BMP, revised 3/1/09, included "complaining" as a target behavior and stated staff were to complete a behavior log each time he engaged in complaining. No additional information regarding his complaining could be found in his record. When asked about the behavior plan during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated she wrote behavior plans based on behaviors that may have been observed in the facility, not directly from the behavior assessments. The Behavior Specialist, who was present during the interview, stated she completed the assessments off historic or tracked data. Individual #2's record also included a written informed consent, signed 3/19/09, which included behavioral levels and standards as follows: Level one: Full privileges, no behavioral restrictions. Maintaining level 1 for 3 months earned $50.00 purchase of chosen item. The standards for level one stated "All residents start at level 1, without restrictions of privileges." Level two: No drink brought into JOG group, no drink during Social Class, no attendance in earned Saturday outing (does not prohibit regular community access). The standards for level two included "Cussing, yelling at staff or peers, spitting, refusing to clean room, refusing to get out of bed, general defiance, refusing to go to school. Must be free of level 2 behaviors for one	W 214		

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W 214	Continued From page 58 week before moving to level 1." The written informed consent did not include information as to why the level 2 restrictions were necessary as his Behavioral Assessment stated socially offensive, disruptive and uncooperative behaviors were not sufficient to warrant a formal objective or plan. Level three: No drink brought into JOG group, no drink during Social Class, no attendance in earned Saturday outing (does not prohibit regular community access), no job opportunities, no Play Station, cannot participate as part of the house government. The standards for level three included "Minor property destruction, refusing to participate in programming, school misconduct, verbal sexual misconduct, elopement without leaving the property, threats to staff or peers, threats to self harm. Must be free of level 3 behaviors for one week before moving to level 2." The written informed consent did not include information as to why the level 3 restrictions were necessary as his Behavioral Assessment stated socially offensive, disruptive and uncooperative behaviors were not sufficient to warrant a formal objective or plan. Additionally, the Behavior Assessment did not include information related to Individual #2 engaging in destruction of property, elopement or threats to harm himself as indicated in his behavioral level standards. Level four: No drink brought into JOG group, no drink during Social Class, no attendance in earned Saturday outing (does not prohibit regular community access), no job opportunities, no Play Station, cannot participate as part of the house government, no Lagoon trip. The standards for	W 214		

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W 214	Continued From page 59 level four included "Aggression to staff or peers, major property destruction, physical sexual misconduct, elopement off of property, self harm, compromise safety of self or others. Must be free of stated level 4 behaviors for one week before moving to level three." Individual #2's Behavior Assessment did not include information related to his engaging in destruction of property, elopement or aggression as indicated in his behavioral level standards. Individual #2's Behavioral Assessment, dated 3/30/09 stated he also engaged in the following: - Inappropriate contact, touch and conduct (attempts to touch others and invade their personal space). - Inappropriate sexual statements (saying inappropriate sexual statements). The Function of Behavior section of the assessment stated "For Inappropriate [sic] contact, conduct or sexual statements - none have been documented over the last two years." No additional information related to the function of the behavior (analyses of the potential causes which may elicit or sustain the behavior) were present in the assessment. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Behavior Specialist stated she looked only at behaviors tracked separately from individuals' sexual offenses and did not include sexually offensive behaviors in the behavior assessments. The facility failed to ensure Individual #2's behavioral assessment contained comprehensive	W 214		

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W 214	Continued From page 60 information. 2. Individual #4's IPP, dated 4/22/09, documented a 15 year old male diagnosed with pervasive developmental disorder NOS, reactive detachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. He was admitted to the facility on 3/26/09. Individual #4's Behavioral Assessment, dated 4/9/09, included a section titled Description of Behavior which documented the following behaviors: - Inappropriate sexual conduct, defined as accessing pornography and using undergarments of family members for masturbation purposes, peeking in at family members in their bedrooms/bathroom. - Socially offensive behavior, defined as behavior that appears threatening to others (he had a knife in bedroom), eye contact that appears threatening and hateful, lies, being prone to exaggeration, could be manipulative, interrupting others when they were talking, and yelling at others. - Depression/suicidal ideation and attempts/homicidal ideation, defined as being associated with guilt when caught doing something wrong (per family report). - Hurtful to self, defined as scratching himself (shoulder) causing minor skin injury. - Hurtful to others: was not defined, but the document stated it may occur when Individual #4 felt vulnerable and not safe. - Unusual, defined as hallucinations and having a history of fire starting. - Sleep disturbances, not defined but the document stated a baseline for sleep was being established.	W 214		

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W 214	Continued From page 61 The Function of Behavior section documented "[Individual # 4's] behavior appear [sic] to coincide with his diagnosis of Asberger's [sic] syndrome." No additional information regarding the function of the behaviors (e.g., escape avoidance, attention seeking, etc.) was included in his record. The section titled Part 2 Function documented "Antecedents may include, when [Individual #4] sees an opportunity, feels depressed or guilty or low self esteem, wants his way, doesn't understand what is being asked of him (due to decreased auditory processing)." It was not clear which antecedents illicited or maintained any of the behaviors identified in Individual #4's Behavioral Assessment. When asked about the function that maintain each specific behavior on 5/4/09 from 1:00 - 3:45 p.m., the Behavior Specialist stated the function of Individual #4's behavior was due to his diagnosis of Asperger's Syndrome. Additionally, Individual #4's Behavioral Assessment stated "Since [Individual #4's] admission to [facility name] on March 26, 2009, he has not exhibited any inappropriate sexual conduct, suicidal-homicidal ideation, behavior that is hurtful to others or himself or unusual behavior. [Individual #4] has interrupted others while they were speaking - a minor behavior issue at this time." However, Individual #4's record contained a safety plan, undated, that included no unsupervised contact with children under the age of 12 years and/or his siblings, close monitoring	W 214		

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W 214	Continued From page 62 when with his peers if they were developmentally delayed, adult supervision by an approved adult who had knowledge of his safety plan 24 hours a day, involvement in an Adolescent Sexual Offender program specifically geared to individuals with developmental disabilities, no unsupervised contact with computers or the Internet, no babysitting or being placed in positions of authority over people under the age of 18, no contact with 1-900 numbers, no contact with pornography, and involvement in a Social/Sexual education group. The assessment did not include information as to why the restrictions listed in the safety plan were necessary as the assessment stated he had not engaged in any maladaptive behavior other than interrupting others when they spoke. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Behavior Specialist stated none of the above behaviors had occurred since Individual #4 was admitted to the facility. The Behavior Specialist stated she looked solely at behaviors tracked separately from individuals' sexual offenses. The facility failed to ensure Individual #4's Behavioral Assessment contained sufficient and comprehensive information related to his specific behavioral needs. 3. Individual #5's 12/17/08 IPP stated he was a 17 year old male whose diagnoses included mild mental retardation, bipolar disorder II, major depressive disorder - recurrent, oppositional defiant disorder NOS, and ADHD. His IPP stated he had a history of sexually inappropriate behavior and had been charged with 5 counts of	W 214		

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W 214	Continued From page 63 lewd and lascivious conduct with a neighbor boy. Individual #5's record did not include a psycho-sexual assessment evaluating risk. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated an assessment had been requested but not completed yet. The facility failed to ensure comprehensive assessments were completed and accurate to address Individual #5's sex offender risk.	W 214	**W227 483.440 (c)(4) Individual Program Plan** Please see Credible Letter dated July 1, 2009	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the individuals' IPPs included objectives to meet the needs for 1 of 7 individuals (Individual #4) whose IPPs and objectives were reviewed. This resulted in a lack of program plans designed to address the needs of the individual in areas most likely to impact his life. The findings include: 1. Individual #4's IPP, dated 4/22/09, documented a 15 year old male diagnosed with pervasive developmental disorder NOS, reactive attachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. a. Individual #4's Behavioral Assessment, dated	W 227		

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W 227	Continued From page 64 4/9/09, documented the following needs in the section titled Desired Behavior/Needs: - Formal objectives for depression type symptoms and suicidal ideation/attempts. - Formal behavior objective for inappropriate sexual conduct. - Guidelines to follow for behaviors that are socially offensive, hurtful to self or others. - Programs/teaching of appropriate sexuality, problem solving skills, coping skills, feelings awareness and appropriate expression of feelings, social boundaries, and social cues (non-verbal communication). However, Individual #4's IPP did not contain objectives for the identified needs. b. Individual #4's Medication reduction program, dated 4/1/09, documented he received Trazodone (an anti-depressant drug) 200 mg for sleep. However, Individual #4's IPP did not contain an objective related to sleep. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated there were no programs for the behaviors listed in Individual #4's Behavior Assessment and there was no program for sleep. The facility failed to ensure Individual #4's IPP contained specific objectives to meet his identified behavioral needs. 2. Individual #2's 6/3/08 IPP stated he was a 15 year old male diagnosed with Asperger's Syndrome, mild mental retardation, PDD and ADHD. His Behavioral Assessment, dated	W 227		

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W 227	Continued From page 65 3/30/09, stated he engaged in the following: - Socially offensive behavior (rudeness, challenging/threatening talk, swearing). - Disruptive behavior (yelling slamming doors, complaining). - Uncooperative behavior (refusals). However, Individual #2's IPP did not contain objectives for the identified needs other than "Complaining." b. Individual #2's Physician's Orders, dated 3/09, stated he received Melatonin (an herbal drug) 3 mg each night for sleep. However, Individual #2's IPP did not contain an objective for sleep. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated there were no programs for the behaviors listed in Individual #2's Behavior Assessment other than complaining, and there was no program for sleep. The facility failed to ensure Individual #1's IPP contained specific objectives to meet his identified behavioral needs.	W 227		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure clear direction to staff was provided in each written training program for 3 of 4 individuals (Individuals #1, #2, and #4) whose training plans	W 234	**W234 483.440 (c)(5)(i) Individual Program Plan** Please see Credible Letter dated July 1, 2009	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	05/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 234	Continued From page 66 were reviewed. This resulted in a lack of instructions to staff being included in individuals' programs. The findings include: 1. Individual #4's IPP, dated 4/22/09, documented a 15 year old male diagnosed with pervasive developmental disorder NOS, reactive attachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. Individual #4's Bathing/Showering program, dated 4/27/09, included an objective stating "[Individual #4] will lather his entire body with soap with a specific verbal prompt in 25 of 30 trials per month for three consecutive months." However, Individual #4's program did not define how the staff was to ensure Individual #4's privacy and ensure he lathered his entire body. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated the plan did not give enough information on how to do the check for lathering and the instructions were not clear. The facility failed to ensure instructions to staff regarding Individual #4's bathing objective contained clear directions on how to implement the teaching strategies. 2. Individual #1's 11/16/08 IPP stated he was an 18 year old male whose diagnoses included mild mental retardation, sexual abuse-child as a victim, and adjustment disorder with disturbance of conduct. His IPP documented a history of perpetrating sexual abuse, and stated he engaged in inappropriate sexual contact including sexual comments and sexual touching.	W 234		

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W 234	Continued From page 67 a. Individual #1's Bathing/Showering program, dated 11/24/08, stated "[Individual #1] will completely wash all body parts (arms, armpits, legs, feet, back, genitals, buttocks, neck and face) in the shower with a non-specific verbal prompt..." Under the "Steps" section of Individual #1's plan it stated "[Individual #1] completely washes all boy [sic] parts (arms, armpits, legs, feet, back, genitals, buttocks, neck and face) while in the shower." The "Methods" section stated "This is the step [Individual #1] is working on. Follow the prompt hierarchy and cue [Individual #1] to completely wash all body parts in the shower starting with independence." Additionally, Individual #1's program stated "If [Individual #1] does not complete the step with a non-specific verbal prompt, provide him with a specific verbal prompt - state, '[Individual #1], please be sure to wash all areas of your body including ____ (the area(s) he has not yet washed).' If [Individual #1] does not complete the step with a specific verbal prompt, stop here, due to [Individual #1's] sexual history he should not be provided with light or full physical assistance. If he needs you to hand him soap, a washcloth, or any other item, you may assist him with this." However, the plan did not describe how staff were to maintain Individual #1's privacy. Additionally, given his sexual history, the plan did not describe how staff were to ensure Individual #1 did not engage in inappropriate sexual behavior as a result of staff being in the bathroom watching him shower, or if male or female staff should be with him in the bathroom.	W 234		

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W 234	Continued From page 68 When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated the methods included in the plan were not clear. b. Individual #1's Toileting program, dated 11/24/08, stated "[Individual #1] will independently complete his toileting..." Under the "Methodology" section of Individual #1's plan it stated "If [Individual #1] starts to leave the bathroom before completing a step cue him following the prompt hierarchy to complete the step...If [Individual #1] does not complete the step with a light physical prompt, stop here. Due to [Individual #1's] sexual history, he should not be provided with full physical assistance." However, the plan did not describe how staff were to maintain Individual #1's privacy during the program, and where staff were to be located while running the program. Additionally, given his sexual history, the plan did not describe how staff were to ensure Individual #1 did not engage in inappropriate sexual behavior as a result of staff being in the bathroom watching him toilet, or if male or female staff should be with him in the bathroom. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated the methods included in the plan were not clear. The facility failed to ensure Individual #1's Bathing and Toileting programs included specific instructions to staff in relation to privacy given Individual #1's sexual history. 3. Individual #2's 6/3/08 IPP stated he was a 15	W 234		

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W 234	Continued From page 69 year old male whose diagnoses included Asperger's Syndrome, mild mental retardation, PDD and ADHD. His IPP stated he had a history of making sexual statements, inappropriate sexual touching, and incidents of inappropriate sexual conduct. Individual #2's Shower/Bathing program, dated 6/3/08, stated "[Individual #2] will independently complete his shower routine..." Under the "Method" section of the plan it stated "If [Individual #2] does not complete the step with a light physical prompt, stop here, due to [Individual #2's] sexual history, he should not be provided full physical assistance." However, the plan did not describe how staff were to maintain Individual #2's privacy. Additionally, given his sexual history, the plan did not describe how staff were to ensure Individual #2 did not engage in inappropriate sexual behavior as a result of staff being in the bathroom watching him shower, or if male or female staff should be with him in the bathroom. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated the methods included in the plan were not clear. The facility failed to ensure Individual #2's Bathing program included specific instructions to staff in relation to privacy given Individual #2's sexual history.	W 234		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met.	W 266	**W266 483.450 Client Behavior & Facility Practices** Please see Credible Letter dated July 1, 2009	

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W 266	Continued From page 70 This CONDITION is not met as evidenced by: Based on observation, review of the facility's policies and procedures, record review and individual and staff interviews it was determined the facility failed to ensure that techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified an individual's behavioral status and needs. 2. Refer to W227 as it relates to the facility's failure to ensure individuals' IPPs included objectives to meet their behavioral needs. 3. Refer to W234 as it relates to the facility's failure to ensure individuals' plans included sufficient direction to staff. 4. Refer to W273 as it relates to the facility's failure to ensure individuals were not allowed to discipline each other, except as part of an organized system of self-government, as set forth in facility policy. 5. Refer to W276 as it relates to the facility's failure to ensure the maladaptive behavior policy was adequately developed to include all positive and intrusive behavior interventions on a hierarchy ranging from most positive to most intrusive.	W 266		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 266	Continued From page 71 6. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage individuals' maladaptive behaviors were incorporated into program plans. 7. Refer to W312 as it relates to the facility's failure to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. The cumulative effect of these negative facility practices significantly impeded the ability of the facility to provide services to meet the behavioral needs of individuals residing in the facility.	W 266		
W 273	483.450(a)(3) CONDUCT TOWARD CLIENT Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy. This STANDARD is not met as evidenced by: Based on review of the facility's policy and procedure for sex offender treatment and staff interviews, it was determined the facility failed to adequately develop policies necessary to prevent discipline of individuals residing at the facility by other individuals for 7 of 7 individuals (Individuals #1 - #7). This resulted in the potential for individuals to be providing disciplinary consequences to other individuals. The findings include: 1. The facility's policy related to Sex Offender Treatment, dated 5/30/08, consisted of four	W 273	**W273 483.450 (a)(3) Conduct Toward Client** Please see Credible Letter dated July 1, 2009	

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 273	Continued From page 72 sections: 1) Initial Assessment of Potential and Current Risk, 2) Implementation of Objectives, 3) Thinking Errors, Problem Solving, and Tracking Maladaptive Behaviors, and 4) Peer Accountability and Support. Under the section titled Peer Accountability and Support, it stated that based on the severity of an individual's issues, "The peer group can determine if a client is to write apology letters to the individuals harmed by his actions, can issue a warning letter to a client for non-compliance to treatment, and can recommend that a client attend a S. O. (Sex Offender) Accountability Board for continued non-compliance to sexual offender treatment." The policy did not specify how the severity of an individual's issues would be accurately assessed nor did it identify whether consents were required for such disciplinary action. Further, the policy was in conflict with the facility's abuse policy, dated 2/10/09, which defined physical neglect as "Applying a behavior management technique that results in, or has the potential to result in physical or psychological harm." When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Behavior Specialist stated the terms and requirements in the policy were not clearly defined. The Administrator, who was also present during the interview, stated the information was an oversight and he did not believe peer accountability had actually been occurring. The facility failed to ensure the policy and procedures for sex offender treatment ensured individuals did not discipline other individuals	W 273		

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W 273	Continued From page 73 residing in the facility.	W 273		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on observation, review of facility policies and procedures, and staff interviews it was determined the facility failed to ensure policies and procedures specified all facility approved interventions to manage individuals' inappropriate behavior. This directly impacted 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in interventions being used to manage inappropriate behavior without the necessary policies and procedures to address the interventions. The findings include: 1. During an observation on 4/28/09 from 6:45 - 8:25 a.m., Individual #1 was noted to have a one-on-one staff. The RSC, who was present during the observation, stated Individual #1, Individual #4, and Individual #6 all had one-on-one staff. The RSC stated Individual #2 , Individual #3, Individual #5 and Individual #7 were to be kept in line of sight. Additionally, the RSC stated Individual #2 had a one-on-one staff at school. These staffing levels were observed throughout the survey. The facility Behavior Method Hierarchy and Definitions policy, dated 5/30/08, included Increased Staff Supervision, defined as "Increasing staff supervision and monitor [sic]."	W 276	**W276 483.450 (b)(1)(i) Management of Inappropriate Client Behavior** Please see Credible Letter dated July 1, 2009	

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 276	Continued From page 74 However, the policy did not define increasing supervision and monitoring. Additionally, the policy did not include one-on-one and line of sight supervision. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the Behavior Specialist stated the policy did not specifically identify one-on-one or line of sight supervision. She further stated one-on-one and line of sight supervision needed to be defined. The facility failed to ensure the Behavior Method Hierarchy and Definitions policy was adequately developed to include and define one-on-one and line of sight staff supervision.	W 276		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were incorporated into the program plans of 3 of 4 individuals (Individuals #2, #3, and #4) whose restrictive behavior interventions were reviewed. This resulted in interventions being used that were not included in the individuals' program plan. The findings include:	W 289	**W289 483.450 (b)(4) Management of Inappropriate Client Behavior** Please see Credible Letter dated July 1, 2009	

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W 289	Continued From page 75 1. Individual #4's IPP, dated 4/22/09, documented a 15 year old male diagnosed with pervasive developmental disorder NOS, reactive detachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. During observations on 4/28/09 from 4:03 - 4:50 p.m. and 5:03 - 6:05 p.m., Individual #4 was noted to have one-on-one staff supervision. However, Individual #4's plan did not include information regarding his one-on-one staff and how it was to be implemented. 2. Individual #3's IPP, dated 12/10/08, documented a 18 year old male diagnosed with Asperger's Syndrome, mild mental retardation, and mood disorder NOS. During observations on 4/28/09 from 4:03 - 4:50 p.m. and 5:03 - 6:05 p.m., Individual #3 was noted to have what appeared to be one-on-one staff supervision. When the RSC was asked at 5:23 p.m., she stated Individual #3 was line of sight supervision but the staff observed working with him did not have responsibility for a second individual at that time. However, line of sight staffing was not included or defined in Individual #3's plan. 3. Individual #2's 6/3/08 IPP stated he was a 15 year old male whose diagnoses included Asperger's Syndrome, mild mental retardation, and ADHD. During observations on 4/28/09 from 4:03 - 4:50 p.m. and 5:03 - 6:05 p.m., Individual #2 was noted to be within line of sight of staff. Staff	W 289		

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W 289	Continued From page 76 working with Individual #2 during the observations stated Individual #2 was to remain within staff's line of sight at all times. Additionally, during an observation at the school on 4/28/09 from 11:10 - 11:55 a.m., Individual #2 was noted to have one-on-one staff supervision. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated line of sight and one-on-one supervision was not included in the the plans for Individual #2, Individual #3, or Individual #4. The facility failed to ensure to the use of one-on-one and line of sight supervision to manage inappropriate behavior was incorporated into plans for Individuals #2, #3, and #4.	W 289		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of the individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 2 individuals (Individuals #2 and #4) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the	W 312	**W312 483.450 (e)(2) Drug Usage** Please see Credible Letter dated July 1, 2009	

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 312	Continued From page 77 drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #4's IPP, dated 4/22/09, documented a 15 year old male diagnosed with pervasive developmental disorder NOS, reactive attachment disorder, mood disorder NOS, PTSD, and Asperger's Syndrome. Individual #4's Physician's Orders, dated 3/09, documented he received Trazodone (an anti-depressant drug) 200 mg. His Medication Reduction Plan, dated 4/1/09, documented he received Trazodone for insomnia. However, the criteria for the medication reduction reduction did not specify what an incident of insomnia was. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated the criteria for reduction was not clear. The facility failed to ensure Trazodone was used only as a comprehensive part of Individual #4's IPP that was directed specifically towards the reduction and eventual elimination of the behavior for which the drug was employed. 2. Individual #2's 6/3/08 IPP stated he was a 15 year old male whose diagnoses included Asperger's Syndrome, mild mental retardation, and ADHD. His Physician's Orders, dated 3/09, stated he received Melatonin (an herbal drug) 3 mg each night. Individual #2's Medication Reduction Plan, dated 4/22/08, stated the criteria for reducing Melatonin was "5 or less episodes of sleep loss (less than 8 hours) per month for 3 months." However, Individual #2's plan did not include a training plan	W 312		

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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W 312	Continued From page 78 to assist Individual #2 to improve sleep without the use of the medication. When asked during an interview on 5/4/09 from 1:00 - 3:45 p.m., the QMRP stated sleep was tracked but no training plan regarding sleep and the use of Melatonin was in place for Individual #2. The facility failed to ensure Individual #2's use of Melatonin was incorporated as an integral part of Individual #2's IPP to reduce the medication.	W 312		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W127, W149, W153, W154, W157 and W158.	MM177	**MM177 16.03.11.075.09** **Protection from Abuse and Restraint** Please see Credible Letter dated July 1, 2009	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	**MM197 16.03.11.075.10(d)** **Written Plans** Please see Credible Letter dated July 1, 2009	
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W266.	MM212	**MM212 16.03.11.075.17 (a)** **Maximize Developmental Potential** Please see Credible Letter dated July 1, 2009	
MM214	16.03.11.075.17(c) Residents' Record The resident's record must include evidence that the resident's habilitation rights are observed.	MM214	**MM214 16.03.11.075.17 (c)** **Residents' Records** Please see Credible Letter dated July 1, 2009	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G053	A. BUILDING _____ B. WING _____	05/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - MILLIKEN	7904 ARLINGTON DRIVE NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM214	Continued From page 1 This Rule is not met as evidenced by: Refer to W124.	MM214		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. The findings include: An environmental survey was conducted on 4/28/09, from 3:44 - 4:05 p.m. and the following concerns were noted: Bathroom #2: - The door knob on the bathroom door was loose (bedroom #1 side). Bathroom #3: - The bathroom door had two holes in it (bedroom #3 side). Living Room: - The two ottomans had frayed and ripped edges.	MM380	**MM380 16.03.11.120.03 (a)** **Building and Equipment** 1. Maintenance was contacted and all needed repairs were completed. 2. The Ottomans are no longer in the home 3. Monthly Maintenance walk-thrus/inspections occur monthly 4. The Maintenance Supervisor is responsible to assure monitoring and compliance. **M410 16.03.11.120.04(h)(v)** **Forced Ventilation** 1. Maintenance was contacted and all needed repairs were completed. 2. Monthly Maintenance walk-thrus/inspeetions occur monthly 3. The Maintenance Supervisor is responsible to assure monitoring and compliance.	
MM401	16.03.11.120.04(h)(v) Forced Ventilation All inside bathrooms and toilet rooms must have	MM401		

Bureau of Facility Standards

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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MM401	Continued From page 2 forced ventilation to the outside. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure all bathrooms had operational forced ventilation to the outside for 3 of 3 individuals (Individuals #2, #4 and #5) who shared a bathroom. The findings include: During an environmental survey conducted on 4/28/09 from 3:44 - 4:05 p.m., the exhaust fan in the #2 bathroom, shared by Individual #2, Individual #4, and Individual #5, was not operational. The bathroom had no window. The RSC, who was present, was immediately notified of the non-operational fan.	MM401	**MM520 16.03.11.200.03 (a) Establishing and Implementing Policies** Please see Credible Letter dated July 1, 2009	
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W104 and W276.	MM520	**MM620 16.03.11.230.05(b) Upgrading Competencies** Please see Credible Letter dated July 1, 2009	
MM620	16.03.11.230.05(b) Upgrading of Competencies The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W191.	MM620		

Bureau of Facility Standards

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	13G053	A. BUILDING _____ B. WING _____	05/05/2009

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MM730	Continued From page 4 prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730		

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MM724	Continued From page 3	MM724		
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W210.	MM724	**MM724 16.03.11.270.01(a) Assessments** Please POC for W210	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W158, W159 and W234.	MM725	**MM725 16.03.11.270.01(b) QMRP** Please see Credible Letter dated July 1, 2009	
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227 and W289.	MM729	**MM729 16.03.11.270.01 (d) Treatment Plan Objectives** Please see Credible Letter dated July 1, 2009	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and	MM730	**MM730 16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Base** Please see Credible Letter dated July 1, 2009	

Preferred Community Homes

July 1, 2009

Nicole Wisenor, Co-Supervisor, Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720

Dear Ms. Wisenor:

Preferred Community Homes – Milliken Heights alleges compliance with the Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions of Participation on Client Protections, Facility Staffing, and Client Behavior and Facility Practices.

Preferred Community Homes has accomplished the following in preparation for a revisit:

- Leadership in the home has changed, with the termination of the previous administrator and QMRP.
    - Preferred Community Homes, Westcare Regional Renee Naylor is acting as temporary Administrator until an appropriate time to transition the new administrator into that position.
        - PCH has hired Rusty Symons, an AQMRP from Belmont Care Center who has 4 years experience with in a Sex Offender Treatment ICF/MR as acting AQMRP of Milliken Heights. At this current time Ann Moss, PCH Behavioral Specialist is acting as QMRP with oversight of Rusty Symons. In addition, Rusty will eventually transition to administrator of the home after being trained by Renee Naylor, Westcare Regional.

    Side Note: * Both Rusty Symons and Ann Moss will be attending the ATSA Convention and will become certified within ATSA in October, 2009
- A team meeting occurred with Jason Byrd and PCH Admin Team to address his roles and responsibilities as consultant Sex Offender Treatment Counselor. These roles and responsibilities were established. In addition, in hiring Rusty Symons, formerly of Belmont Management, a professional relationship exists between the AQMRP and the Sex Offender Treatment Counselor which will facilitate communication with the team.
- The team from Belmont Management provided specific training on the IPP Process including the Sexual Offender component with the Milliken Team. The Combine team completed an IPP meeting for one specific client. The IPP along

with programs are currently being prepared for implementation. This process will be implemented for the other individuals in the home.

- The Administrator, the AQMRP and the Sex Offender Treatment Counselor walked through the home assessing each individual's bedroom along with the common areas to determine how the environment needed to be modified to be more appropriate to the treatment aspect. The inappropriate pictures have been removed.
- The Sex Offender Treatment Counselor has communicated with the Probation officer (Dixie) and the team has begun monthly teleconference calls. This began in June as the Probation officer attended the individual's IPP meeting. At this meeting the probationary guidelines were outlined. In addition, the next call is scheduled for July 6, 2009. It was also determined that at any time probationary guidelines are violated or if there is a significant event the communication will be immediate.
- The Sex Offender Treatment Counselor provided the following training:
    - Administrative Team Training on what specifically is sex offender treatment. Definition of the Journey Program.
    - Administrative Team Training on The Behavioral Management aspect of Sex Offender treatment related to the Journey.
    - Direct Care Staff Training on Sex Offender Treatment along with behavior modifications specific to the sex offender treatment.
- The treatment groups have been established as follows:
    - Responsibility Group will occur one time per week with the residents. Two professional staff unrelated to the Milliken staff has been trained and began participating in the Responsibility Group to avoid conflict of interest issues possible when prior home management staff was participating. Jason Byrd, the Sex Offender Counselor attends this group weekly.
    - The Journey Group will occur one time per week. Ann Moss, Behavioral Specialist has begun attending along with Jason Byrd as a group facilitator. Jason has trained Ann Moss to be able to assist and facilitate. At the end of each group session, the treatment team goes over what specifically occurred in group that week, debriefs and discusses where the group is headed next week.
    - The Social Sexual Group also meets weekly. This group is being facilitated by Tom Moss, Licensed Social Worker. Jason Byrd provided hands on in group training with Tom Moss to assure he was capable of facilitating such a group. After each group meeting, the treatment team goes over what specifically was discussed this week and what will be discussed the following week.

- IPP Addendum meetings have occurred to discuss sexual offender treatment goals for each resident of Milliken. Programs are currently being written to be implemented.
- Jason Byrd, Sex Offender Treatment Counselor began a two day a week visit to PCH. This will continue until the Milliken treatment team feels assured the

program is running appropriately. At that time the treatment team will assess the amount of time Jason Byrd spends at PCH.

- Risk Assessments which needed to be completed have been completed.
- We continue with all aspects of the POC given to surveyors in regards to the IJ.
    - No staff will work graveyard prior to being trained.
    - Graveyard continues to be prohibited from bring any personal electronic equipment into the home.
    - Clear guidelines have been establish which require staff to be located in each of the two client bathrooms, with the third rotating through the home on five minute client checks. The checks are documented.
    - For a period of three weeks, a supervisory staff remained on the floor for the entirety of graveyard. Currently twice weekly random graveyard observation by the RSC occur. The AQMRP has also participated in random observations.
    - All graveyard staff are 21 years of age or older.
    - A cleaning company was hired to complete cleaning duties to assure graveyards continue to be prohibited from doing cleaning duties
- PCH Milliken no longer hires staff under the age of 21 years to work in the home. However, staff previously hired under the age of 21 remain, but are specifically not to work with any client with probationary guidelines prohibiting contact with those 18 years or younger.
- AQMRP provided client profile training to direct care staff. This training outlined client diagnosis, history, assessed risks, and restrictions.
- The Administrator provided training on Offender Treatment Safety Guidelines.
- The Contract for Sexual Offender Treatment has been developed.
    - Verbal consent has been garnered on all contracts and we are awaiting the signed copies of these agreements.

- The Suicide Policy has been revised and updated. Please see attached policy
    - Staff have had formal in-class room training on the suicide policy.
    - Staff have had formal in class room training on Depression, signs and symptoms. ADHD, signs and symptoms. Autism and Pervasive Developmental Disorder.
    - Staff have participated in random calling and interviewing regarding the Suicide policy to assure familiarity with the policy and where to find it if needed.
    - A Suicide Information Sheet had been developed and implemented to assist the Administrator or AOD to gather the appropriate information, document immediate actions taken, document the initial instructions from the LPC and also document the follow up.
    - Client Inventory Sheet developed and implemented to assist in documentation of all items removed from a client.
    - IPP Addendum meetings have occurred for those with a history of suicide ideation/attempts. Behavior programs are in the process of being revised.
    - The Administrator met with the Director of Special Education along with the principal, teacher and IBI director of the school to discuss the Suicide

Policy and Procedure, along with the Abuse, Neglect, Mistreatment and injuries of unknown source policy.

- Lines of Communication were defined.
- The school has agreed to allow PCH staff to attend school with any resident who is on "Suicide Watch".

- The Behavioral Hierarchy has been revised and updated. Please see attached.
- Direct Care Staff were retrained on the Abuse, Neglect, Mistreatment and Unknown injuries policy and procedure.
- Administrators were retrained by the Regional Director on how to complete a thorough investigation.
- PCH implemented a weekly debriefing meeting, in which we discuss all staff to client incidents and what has occurred within the investigation, the conclusions and the actions taken. To assure that we are consist in implementation of the Abuse, Neglect, Mistreatment and Injuries of Unknown source.

If you have any further questions, please feel free to contact me at 208-855-9142

Renee Naylor
PCH- Milliken Acting Administrator